Table of Contents

Appendix

Appendix 1

Notice to Wisconsin Medicaid Recipients Regarding This Personal Care Agency

_____

Name of Personal Care Agency

is paid by Wisconsin Medicaid for personal care. This agency is not Medicare-certified and so Medicare does not pay this agency for personal care. Wisconsin Medicaid will not pay this agency for personal care for any patient who is eligible for these services under Medicare.

By signing below, I am saying I understand that:

- If I become eligible for personal care services under Medicare, Wisconsin Medicaid will not pay this agency for my personal care unless this agency shares my care with another agency that can be paid by Medicare.
- If this agency does not share my care with another agency that can be paid by Medicare, this agency will discharge me so that I can receive care from another agency that can be paid by Medicare.
- This agency cannot bill me personally for personal care or any other service covered under Medicare or Wisconsin Medicaid.
- If I have questions regarding this policy, I can call Wisconsin Medicaid Recipient Services at (800) 362-3002 or (608) 221-5720.

_____

Wisconsin Medicaid Recipient Signature or Person Legally Responsible for Recipient — Date

* * *

By signing below, the registered nurse (RN) who supervises this recipient's personal care worker verifies that if this recipient was unable to read the form, the RN read it to the recipient.

_____

Registered Nurse Signature — Date

Appendix 2

UB-92 Claim Form Instructions

Use these billing instructions to avoid denied claims or inaccurate claim payment. Enter all required data on the UB-92 claim form in the appropriate data item. Do not include attachments. UB-92 items are required unless "not required" is specified.

These instructions will help you complete a UB-92 claim only for Wisconsin Medicaid. For complete billing instructions, refer to the UB-92 Billing Manual prepared by the State Unified Billing Committee (SUB-C). The UB-92 Billing Manual contains important coding information not available in this appendix. You may purchase the UB-92 Billing Manual by writing to:

Wisconsin Health and Hospital Association
5721 Odana Road
Madison, Wisconsin 53719-1289
(608) 274-1820

Wisconsin Medicaid recipients receive a plastic identification card (the Forward card) when initially enrolled in Wisconsin Medicaid. Always see this card before providing services. Please use the information exactly as it appears on the ID card to complete the patient information.

Item 1: Provider Name, Address, and Telephone Number
Enter the name, address, city, state and ZIP code of the billing provider.

Item 2: Unlabeled Field (not required)

Item 3: Patient Control Number (not required)
Providers may enter the patient's internal office account number. This number will appear on the Wisconsin Medicaid fiscal agent Remittance and Status Report (maximum of 17 characters for paper, electronic, or tape claims).

Item 4: Type of Bill
Enter the 3-digit code indicating the specific type of claim. The first digit identifies the type of facility. The second digit classifies the type of care. Personal care/home health providers are required to use bill type 33X. The third digit ("X") indicates the billing frequency and should be assigned as follows (331, 332, 333, or 334):

1 = Inpatient admit through discharge claim
2 = Interim bill - first claim
3 = Interim bill - continuing claim
4 = Interim bill - final claim

Item 5: Federal Tax Number (not required)

Item 6: Statement Covers Period (from - through) (not required)

Item 7: Covered Days (not required)

Item 8: Noncovered Days (not required)

Item 9: Coinsurance Days (not required)

Item 10: Lifetime Reserve Days (not required)

Item 11: Unlabeled Field (not required)

Item 12: Patient Name
Enter the recipient's last name, first name, and middle initial exactly as it appears on the plastic Wisconsin Medicaid identification card (the Forward card), including spaces and hyphens.

Item 13: Patient's Address (not required)

Item 14: Patient's Date of Birth (not required)

Item 15: Patient's Sex (not required)

Item 16: Marital Status (not required)

Item 17: Date of Admission (not required)

Item 18: Hour of Admission (not required)

Item 19: Type of Admission (not required)

Item 20: Source of Admission (not required)

Item 21: Discharge Hour (not required)

Item 22: Patient Status (not required)

Item 23: Medical/Health Record Number (optional)
This number will not appear on the Remittance and Status Report.

Items 24-30: Condition Codes (Required, if applicable.)

Code	Explanation of Code
01	*Military service related:* Medical condition incurred during military service.
02	*Condition is employment related:* Patient alleges that medical condition is due to environment/events resulting from employment.
03	*Recipient covered by insurance not reflected here:* Indicates that the patient or a representative has stated that coverage may exist beyond that reflected on this bill.
05	*Lien has been filed:* Provider has filed legal claim for recovery of funds potentially due a recipient as a result of legal action initiated by or on behalf of the patient.
08	*Beneficiary would not provide information concerning other insurance coverage:* Enter this code if the beneficiary would not provide information concerning other insurance coverage.

See UB-92 Billing Manual for additional codes.

Items 32-35(a-b): Occurrence Codes and Dates (Required, if applicable.)
If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates are required to be printed in the MMDDYY format.

Code	Explanation of Code
01	*Auto Accident:* Code indicating the date of an auto accident.
02	*Auto Accident/No Fault Insurance:* Code indicating the date of an auto accident where the state has applicable no-fault liability laws.
03	*Accident/Tort Liability:* Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	*Accident/Employment Related:* Code indicating the date of an accident relating to the patient's employment.
05	*Other Accident:* Code indicating the date of an accident not described by the above codes.
06	*Crime Victim:* Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
25	*Date Benefits Terminated by Primary Provider:* Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
42	*Date of Discharge:* For final bill of hospice care, enter the date the beneficiary terminated the election of hospice care.

See UB-92 Billing Manual for additional codes.

Item 36(a-b): Occurrence Span Code and Dates (not required)

Item 37: Internal Control Number (ICN)/Document Control Number (DCN) (not required)

Item 38: Responsible Party Name and Address (not required)

Items 39-41(a-d): Value Codes and Amounts (Required, if applicable.)
If appropriate, enter a value code and the related dollar amount necessary for processing this claim. The value code structure is intended to provide additional reporting capabilities.

Code	Explanation of Code
22	*Surplus:* Spenddown required to be entered if patient spenddown occurs. This code should be entered together with the dollar amount.

Item 42: Revenue code
Enter revenue code 001on the last line, indicating the line on which the sum of all charges on the claim is placed.

Item 43: Revenue Description
Enter the date of service in the MMDDYY format either in this item or in Item 45.

When series billing (i.e. billing from two to four dates of service on the same line), indicate the dates of service in the following format: MMDDYY MMDD MMDD MMDD. Indicate the dates in ascending order.

Providers may enter up to four consecutive dates of service for each revenue or procedure code if:

- All dates of service are in the same calendar month.
- All procedures performed are identical.
- All procedures were performed by the same provider.

If it is necessary to indicate more than four dates of service per procedure code, indicate the dates on subsequent lines. On paper claims, no more than 23 lines may submitted on a single claim, including the "total charges" line.

Item 44: HCPCS/Rates
Enter the appropriate five-digit procedure code.

Item 45: Service Date
Enter the date of service in the MMDDYY format either in this item or in Item 43 (multiple dates of service are required to be indicated in Item 43).

Item 46: Units of Service
Enter the total number of services billed on each line item.

Item 47: Total Charges (by revenue code category)
Enter the total charge for each line item. For revenue code 001 (total charges), enter the grand total for all services submitted on the claim.

Item 48: Noncovered Charges (not required)

Item 49: Unlabeled Field (not required)

Item 50: Payer Identification
Indicate Medicaid ("T19-WI Medicaid") and all third-party payers (including Medicare) with possible involvement in this claim. All coverages indicated on the recipient's Medicaid identification card must be addressed.

Item 51: Provider Number
Enter the provider's eight-digit provider number on line B.

Item 52: Release Information Certification Indicator (not required)

Item 53: Benefits Assigned (not required)

Item 54: Prior Payments-Payer and Patient (Required, if applicable.)
If applicable, enter the amount the provider has received toward payment of this bill prior to the billing date by the indicated payer. If "other insurance" denied the claim, enter $0.00 (do not indicate Medicare payment).

Item 55: Estimated Amount Due (not required)

Item 56: Unlabeled Field (not required)

Item 57: Unlabeled Field (not required)

Item 58: Insured's Name (not required)

Item 59: Patient's Relationship to Insured (not required)

Item 60: Certification Number, Social Security Number, Health Insurance Claim Number Identification Number
On line B, enter the recipient's 10-digit Medicaid ID number as it appears on his or her Forward card.

Item 61: Insured Group Name (not required)

Item 62: Insurance Group Number (not required)

Item 63: Treatment Authorization Code
On line B, enter the seven-digit prior authorization number from the approved Prior Authorization Request Form. Services authorized under separate prior authorization numbers are required to be billed on separate claim forms with their respective prior authorization numbers.

Item 64: Employment Status Code (not required)

Item 65: Employer Name (not required)

Item 66: Employer Location (not required)

Item 67: Principal Diagnosis Code
The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) diagnosis code is required to be entered for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. Manifestation ("M") codes are not valid diagnosis codes for Wisconsin Medicaid.

Items 68-75: Other Diagnosis Codes
Enter the full ICD-9-CM diagnosis codes corresponding to additional conditions related to treatment billed on the claim. Other diagnosis codes will permit the use of ICD-9-CM "E" codes. Manifestation ("M") codes are not valid diagnosis codes for Wisconsin Medicaid.

Item 76: Admitting Diagnosis (not required)

Item 77: External Cause of Injury (E-Code) (not required)

Item 78: Race/Ethnicity (not required)

Item 79: Procedure Coding Method Used (not required)

Item 80: Principal Procedure Code and Date (not required)

Item 81: Other Procedure Codes and Dates (not required)

Item 82(a-b): Attending Physician ID (not required)

Item 83(a-b): Other Physician ID (not required)

Item 84: Remarks (Enter information when applicable.)
Private Insurance
Third-party insurance (private insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing as determined by Wisconsin Medicaid.

- When the recipient has dental (DEN) insurance only or has no private insurance, leave Item 84 blank.
- When the recipient has Wausau Health Protection Plan (HPP), Blue Cross (BLU), Wisconsin Physicians Service (WPS), CHAMPUS (CHA), or some other (OTH) private insurance, ***and*** the service requires third party billing according to the All-Provider Handbook, and *Medicaid Update*, dated December 1998 (No. 98-38), then one of

the following three other insurance (OI) explanation codes ***is required to*** be indicated in the ***first*** box of Item 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by health insurance. In Item 54 of this claim form, indicate the amount paid by health insurance to the provider or to the insured.
OI-D	DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do ***not*** use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES. The recipient has health insurance, but it was not billed for reasons including, but not limited to: • Recipient denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • Health insurance failed to respond to initial and follow-up claims. • Benefits not assignable or cannot get assignment.

When the recipient is a member of an HMO, one of the following must be indicated, ***if applicable***:

Code	Description
OI-P	PAID by HMO. The amount paid is indicated on the claim.
OI-H	HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO are not reimbursable by Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Medicaid for services which are included in the capitation payment.

Medicare

Medicare codes cannot be used if one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The ***non-physician*** provider's Medicaid file shows he or she is not Medicare certified. (This does not apply to physicians because Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits (EOMB), but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary.
The following Medicare disclaimer codes can be used when appropriate.

Code Description

M-1 Medicare benefits exhausted. This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service provided is covered by Medicare Part B, but is not payable due to benefits being exhausted.

M-5 Provider is not Medicare certified. This code can be used when providers are identified in Medicaid files as being Medicare certified, but are billing for dates of service before or after their Medicare certification effective dates.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A but not for the date the service was provided.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B but not for the date the service was provided.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

M-6 Recipient not Medicare eligible. This code can be used when Medicare denies payment for services related to ***chronic renal failure*** (diagnosis code 585) because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Medicaid files as not eligible for Medicare. Use the M-6 disclaimer code in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

M-7 Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A, but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B, but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

M-8 Noncovered Medicare service. This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Leave the element blank if Medicare is not billed because the recipient's Forward card indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit (EOMB) to the claim and do not indicate a Medicare disclaimer code in this blank. Do not enter Medicare paid amounts on the claim form. Refer to the All-Provider Handbook for more information about submitting claims for dual-entitlees.

Item 85 - Provider Representative Signature

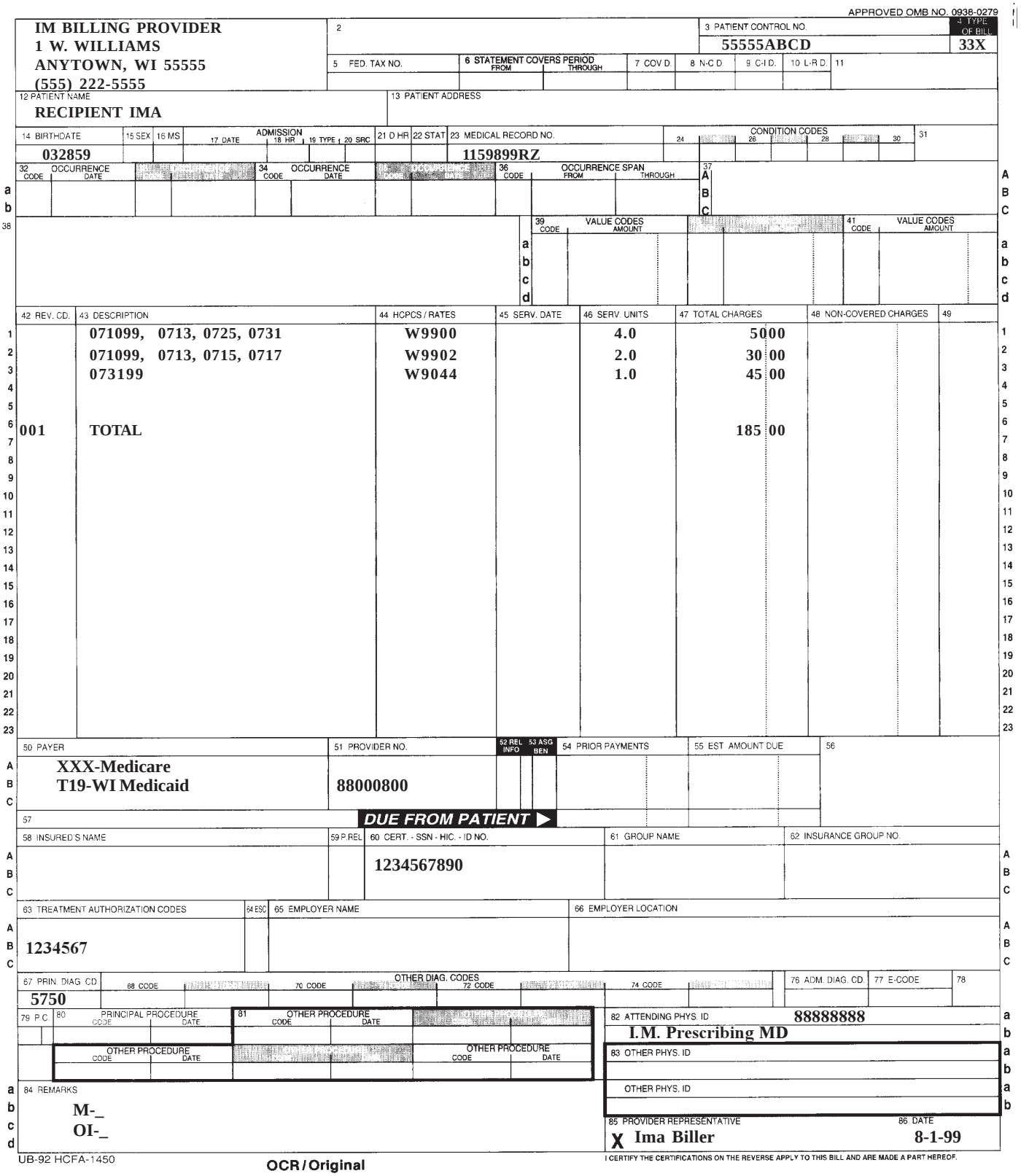
The provider or the authorized representative is required to sign in Item 85. This may be a computer printed name or a signature stamp.

Item 86 - Date Bill Submitted

Enter the date on which the claim is submitted to Wisconsin Medicaid in the MMDDYY format.

Appendix 3

UB-92 Claim Form Example - Personal Care Services Series Billing



APPROVED OMB NO. 0938-0279

1 PROVIDER NAME, ADDRESS, PHONE	IM BILLING PROVIDER 1 W. WILLIAMS ANYTOWN, WI 55555 (555) 222-5555
2	
3 PATIENT CONTROL NO.	55555ABCD
4 TYPE OF BILL	33X
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM / THROUGH	
7 COV D.	
8 N-C D.	
9 C-I D.	
10 L-R D.	
11	
12 PATIENT NAME	RECIPIENT IMA
13 PATIENT ADDRESS	
14 BIRTHDATE	032859
15 SEX	
16 MS	
17 ADMISSION DATE	
18 HR	
19 TYPE	
20 SRC	
21 D HR	
22 STAT	
23 MEDICAL RECORD NO.	1159899RZ
24 CONDITION CODES	
26	
28	
30	
31	
32 OCCURRENCE CODE / DATE	
34 OCCURRENCE CODE / DATE	
36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39 VALUE CODES CODE / AMOUNT	
41 VALUE CODES CODE / AMOUNT	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	071099, 0713, 0725, 0731	W9900		4.0	5000		
	071099, 0713, 0715, 0717	W9902		2.0	3000		
	073199	W9044		1.0	4500		
001	TOTAL				18500		

50 PAYER	XXX-Medicare T19-WI Medicaid
51 PROVIDER NO.	88000800
52 REL. INFO	
53 ASG BEN	
54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE	
56	
57	DUE FROM PATIENT ▶
58 INSURED'S NAME	
59 P.REL	
60 CERT. - SSN - HIC. - ID NO.	1234567890
61 GROUP NAME	
62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES	1234567
64 ESC	
65 EMPLOYER NAME	
66 EMPLOYER LOCATION	
67 PRIN. DIAG. CD.	5750
68 CODE	
OTHER DIAG. CODES 70 CODE / 72 CODE	
74 CODE	
76 ADM. DIAG. CD.	
77 E-CODE	
78	
79 P.C.	
80 PRINCIPAL PROCEDURE CODE / DATE	
81 OTHER PROCEDURE CODE / DATE	
OTHER PROCEDURE CODE / DATE	
OTHER PROCEDURE CODE / DATE	
82 ATTENDING PHYS. ID	88888888 I.M. Prescribing MD
83 OTHER PHYS. ID	
OTHER PHYS. ID	
84 REMARKS	M-_ OI-_
85 PROVIDER REPRESENTATIVE	X Ima Biller
86 DATE	8-1-99

UB-92 HCFA-1450 **OCR / Original**

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Appendix

Appendix 4

Billing Reference Guidelines

Rounding Guidelines for Personal Care Services and Travel Time

The following chart illustrates the rules of rounding and gives the appropriate billing unit(s):

Time (in minutes)	Unit(s) Billed
1-30	0.5
31-44	0.5
45-60	1.0
61-74	1.0
75-90	1.5
91-104	1.5
105-120	2.0
121-134	2.0
etc.	etc.

Allowable Personal Care Procedure Codes

Procedure Code	**Description**
	Bill units in time increments
W9900	Personal Care by Personal Care-Only Agency
W9903	Personal Care by Dually Certified Home Health/Personal Care Agency
W9902	Personal Care Travel Time
	Bill units in visit increments
W9906	Registered Nurse Supervisory Visit (recipient receives only unskilled services) Wisconsin Medicaid reimbursement limited to once every 50-60 days
W9044	Personal Care Supervisory Visit (recipient also receives skilled services) Wisconsin Medicaid reimbursement limited to once a month if medically necessary

Appendix 4
(cont.)

Allowable Place of Service (POS) Codes
Personal Care Services

POS Code	Description
4	Home (personal care services, RN supervisory visits, and travel time are provided in the home)
0	Other

Allowable Type of Service (TOS) Codes
Personal Care Worker

TOS Code	Description
1	Medical
9	Other (use only when billing for disposable medical supplies)

Appendix 5

HCFA 1500 Claim Form Instructions For Disposable Medical Supplies (DMS)

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate. No other elements are required.

Note: Medicaid providers should ***always*** verify recipient eligibility before rendering services.

Element 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "D" in the Medicaid check box for the service billed.

Element 1a - Insured's I.D. Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial. Write the name exactly as it appears on the Wisconsin Medicaid identification card.

Element 3 - Patient's Birth Date, Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/CCYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Injured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Third-party insurance (private insurance coverage) must be billed prior to billing Medicaid, unless the service does not require third-party billing as determined by Medicaid.

- When the recipient has dental (DEN) insurance only or has no private insurance, leave Element 9 blank.
- When the recipient has Wausau Health Protection Plan (HPP), Blue Cross (BLU), Wisconsin Physicians Service (WPS), CHAMPUS (CHA), or some other (OTH) private insurance, ***and*** the service requires third party billing according to the All-Provider Handbook, and *Medicaid Update*, dated December, 1998 (No. 98-38), then one of the following three other insurance (OI) explanation codes ***is required to*** be indicated in the ***first*** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by health insurance. In Element 29 of this claim form, indicate the amount paid by health insurance to the provider or to the insured.
OI-D	DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do ***not*** use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES. The recipient has health insurance, but it was not billed for reasons including, but not limited to: • Recipient denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • Health insurance failed to respond to initial and follow-up claims. • Benefits not assignable or cannot get assignment.

When the recipient is a member of an HMO, one of the following must be indicated, ***if applicable***:

Code	Description
OI-P	PAID by HMO. The amount paid is indicated on the claim.
OI-H	HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO are not reimbursable by Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Medicaid for services which are included in the capitation payment.

Element 10 - Is Patient's Condition Related to: (not required)

Element 11 - Insured's Policy Group or FECA Number
Use the ***first*** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Bill Medicare before billing Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The ***non-physician*** provider's Medicaid file shows he or she is not Medicare certified. (This does not apply to physicians because Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits (EOMB), but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary.
The following Medicare disclaimer codes can be used when appropriate:

Code Description

M-1 Medicare benefits exhausted. This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service provided is covered by Medicare Part B, but is not payable due to benefits being exhausted.

M-5 Provider is not Medicare certified. This code can be used when providers are identified in Medicaid files as being Medicare certified, but are billing for dates of service before or after their Medicare certification effective dates.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A but not for the date the service was provided.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B but not for the date the service was provided.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

M-6 Recipient not Medicare eligible. This code can be used when Medicare denies payment for services related to ***chronic renal failure*** (diagnosis code 585) because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Medicaid files as not eligible for Medicare. Use the M-6 disclaimer code in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

M-7 Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A, but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B, but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

M-8 Noncovered Medicare service. This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Leave the element blank if Medicare is not billed because the recipient's Forward card indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit (EOMB) to the claim and do not indicate a Medicare disclaimer code in this blank. Do not enter Medicare paid amounts on the claim form. Refer to the All-Provider Handbook for more information about submitting claims for dual-entitlees.

Element 12 - Patient's or Authorized Person's Signature (not required)

Element 13 - Insured's or Authorized Person's Signature (not required)

Element 14 - Date of Current Illness, etc. (not required)

Element 15 - If Patient Has Had Similar Illness, Give First Date (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source
Enter the referring or prescribing physician's name.

Element 17a - I.D. Number of Referring Physician
Enter the referring/prescribing physician's six-character UPIN number. If the UPIN number is not available, enter the eight-digit Medicaid provider number or license number of the referring physician.

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use (not required)

Element 20 - Outside Lab?
If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab.

Element 21 - Diagnosis or Nature of Illness or Injury
Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Medicaid denies claims without the appropriate ICD-9-CM diagnosis code. One source to order the complete ICD-9-CM code book is:

St. Anthony Publishing, Inc.
P. O. Box 96561
Washington, D.C. 20090
(800) 632-0123

Element 22 - Medicaid Resubmission Code (not required)

Element 23 - Prior Authorization Number
Enter the seven-digit prior authorization (PA) number from the approved PA request form. Services authorized under multiple PAs are required to be billed on a separate claim form with their respective PA numbers. Disposable medical supplies (DMS) requested over the monthly limitations must be prior authorized.

Element 24A - Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY or MM/DD/CCYY format in the "From" field.
- When billing for two, three, or four dates of service on the same detail line, enter the first date of service in MM/DD/YY or MM/DD/CCYY format in the "From" field, and subsequent dates of service in the "To" field by listing ***only*** the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service (TOS) code.

- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge ***per detail line*** in Element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

Leave the element blank if Medicare is not billed because the recipient's Forward card indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit (EOMB) to the claim and do not indicate a Medicare disclaimer code in this blank. Do not enter Medicare paid amounts on the claim form. Refer to the All-Provider Handbook for more information about submitting claims for dual-entitlees.

Element 24B - Place of Service
Enter the appropriate Wisconsin Medicaid single-digit place of service (POS) code for each service. Refer to Appendix 3 of this section for a list of all allowable place of service codes and their descriptions.

Element 24C - Type of Service
Enter the appropriate Wisconsin Medicaid single-digit type of service (TOS) code for each service. Refer to Appendix 3 of this section for a list of all allowable type of service codes and their descriptions.

Element 24D - Procedures, Services, or Supplies
Enter the single most appropriate five-character HCFA Common Procedure Coding System (HCPCS) code, or local procedure code. Claims received without the appropriate HCPCS or local code are denied by Medicaid.

Only the HCPCS procedure codes in the most recent DMS Index (which is updated and sent out to providers periodically) are covered by Medicaid.

Modifiers
Enter the appropriate Medicaid modifier in the "Modifier" column of Element 24D. Medicaid-allowable modifiers can be found in the DMS Index.

Element 24E - Diagnosis Code
When multiple procedures related to different diagnoses are listed, enter the diagnosis code that corresponds with the procedure code in Element 24D. Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F - Charges
Enter the total charge for each line item.

Element 24G - Days or Units
Enter the total number of services billed for each line item.

Element 24H - EPSDT/Family Plan
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if ***both*** HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

Element 24I - EMG
Enter an "E" for ***each*** procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this Element blank.

Element 25 - Federal Tax I.D. Number (not required)

Element 26 - Patient's Account Number
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status (R/S) Report.

Element 27 - Accept Assignment (not required)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in this element, "OI-P" must be indicated in Element 9.) Do ***not*** enter Medicare paid amounts in this field.

Element 30 - Balance Due
Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 - Signature of Physician or Supplier
The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/CCYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 33 - Physician's, Supplier's Billing Name, Address, ZIP Code and Phone #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 6

HCFA 1500 Claim Example - Disposable Medical Supplies (DMS)

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) D | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 5555555555

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: 03 28 59 SEX M [ ] F [x]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Robin Rd.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX)XXX-XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 123456

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 5750 3. 2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 03 99	4	9	A6201		1	45 00	20				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Ima Biller 8-1-99

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing PCW
1 W. Williams
Anytown, WI 55555

PIN# GRP# 88000800

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Appendix

Appendix 7

Avoiding Common Denials

Some common denial codes from claims, and the appropriate solutions for these denials, are shown in the box below.

Explanation of Benefit Code (Denial Code)	Correction
100- Claim previously/partially paid on 24XXXXXXXXXX on Remittance Advice date 02XXXX. Adjust paid claim.	Review paid claim and adjust appropriately.
399- Date of service must fall between the prior authorization grant and expiration date.	Review date of service on claim. Does it fall between the grant and expiration date on the prior authorization (PA)? If dates of service are from two PAs, you must split bill each with the correct PA number (only one PA number is allowed per claim).
970-Personal care in excess of 50 hours per calendar year requires PA.	PA is required for hours billed and paid in excess of 50 per calendar year.
322- Service(s) denied/cutback – the maximum PA service limitation frequency allowance has been exceeded.	The numbers of hours for the PA listed on the claim have been used up. If you have received an approved PA for more hours, bill with the correct PA number.
010- Recipient is eligible for Medicare.	Use the appropriate Medicare disclaimer code or attach Medicare EOB if Medicare paid.
388- Incorrect or Invalid type of service, National Drug Code or procedure code.	Enter the correct procedure code in Item 44.
652- Denied supervisory visit for unskilled cases allowed once per 60 days.	Supervisory visit only allowed once per 60 days using procedure code W9906.
398- PA number submitted is missing or incorrect.	Enter the correct seven-digit PA number in Item 63.
281- Recipient Wisconsin Medicaid identification number is incorrect.	Enter the correct 10-digit Medicaid ID number in Item 60 of the UB-92 Claim Form. Verify correct Medicaid ID number with one of the eligibility resources available.
614- Recipient's first name does not match number.	Enter recipient's name, as it appears on your eligibility file, in Item 12 of the UB-92 Claim Form. Verify name with one of eligibility resources available.
172- Recipient not eligible for date of service.	Verify recipient's eligibility with one of the eligibility resources available.
171- Claim/adjustment received after 12 months from the date of service.	See the All-Provider Handbook for late billing exceptions.

Glossary of Common Terms

Activities of daily living (ADL)
Activities of daily living are activities relating to the performance of self care, including dressing, feeding or eating, grooming, and mobility.

Coverage determination software (CDS)
Coverage determination software is computer software that providers are required to use for recipients who are eligible for both Wisconsin Medicaid and Medicare. The software helps providers identify when they should bill Medicare before billing Wisconsin Medicaid.

Community Services Deficit Reduction Benefit (CSDRB)
Community Services Deficit Reduction Benefit is a Wisconsin Medicaid program that makes federal financial participation funds available to counties, local health departments and tribal agencies to reimburse these agencies for funds they expend in excess of Wisconsin Medicaid reimbursement for personal care and selected other non-institutional services.

Date of service
The date of service is the calendar date on which a specific medical service is performed.

Disposable medical supplies (DMS)
Disposable medical supplies are medically necessary items which have a very limited life expectancy and are consumable, expendable, disposable, or nondurable.

Dual entitlee
A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both, is a dual entitlee.

Dually certified agency
A dually certified agency is an agency that is Medicaid-certified to provide both home health and personal care services.

HCFA 1500
The HCFA 1500 is the Health Care Financing Administration claim form used for billing DMS.

Medicare
Medicare is a national health insurance program for people 65 years of age and older, certain younger people with disabilities, and people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Personal care worker (PCW)
A personal care worker is an individual employed by a personal care provider certified under HFS 105.17, Wis. Admin. Code, or under contract to the personal care provider to provide personal care services under the supervision of a registered nurse.

Provider
A personal care provider is a home health agency, county department, independent living center, tribe, or public health agency that has been certified by Wisconsin Medicaid to provide personal care services to recipients and to be reimbursed by Wisconsin Medicaid for those services.

Place of service (POS)
The place of service is the place where the service was performed. For Wisconsin Medicaid prior authorization and billing purposes, it is identified by a single-digit code.

Qualified Medicare Beneficiary Only (QMB-Only)
QMB-Only recipients are only eligible for Medicaid coverage of the coinsurance and the deductibles for Medicare-allowed claims.

Registered nurse (RN)
A registered nurse is a person who holds a current Wisconsin license as a registered nurse under ch. 441, Wis. Stats., or, if practicing in another state, is registered with the appropriate licensing agency in that state.

Supervision
Supervision of personal care services is required to be performed by a qualified RN who reviews the Plan of Care (POC), evaluates the recipient's condition, and observes the personal care worker (PCW) performing assigned tasks at least every 60 days. Supervision requires intermittent face-to-face contact between supervisor and assistant and regular review of the assistant's work by the supervisor according to HFS 101.03(173), Wis. Admin. Code. Supervisory review includes:

- A visit to the recipient's home.
- Review of the PCWs daily written record.
- Discussions with the physician of any necessary changes in the POC, according to HFS 107.112(3)(c), Wis. Admin. Code.

Travel time
Travel time is the time spent traveling to and from the recipient's residence and the previous or following personal

care appointment, the personal care worker's residence, or the provider's office.

Type of service (TOS)
The type of service identifies the general category of medical services. For Wisconsin Medicaid prior authorization and billing purposes, it is identified by a single-digit code.

UB-92
The UB-92 is the claim form used for personal care services.

Usual and customary charge
The provider's charge for providing the same service to persons not entitled to Medicaid benefits is the usual and customary charge.